

**STATE OF RHODE ISLAND
OFFICE OF THE CHILD ADVOCATE**



**Report of the
CHILD FATALITY REVIEW PANEL
A REVIEW OF ONE CHILD FATALITY
JUNE 2019**

The Office of the Child Advocate
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TABLE OF CONTENTS

	<u>PAGE</u>
PREFACE.....	3
INTRODUCTION	4
EXECUTIVE SUMMARY	5
FINDINGS	30
I. General Findings.....	30
II. Licensing.....	34
III. Family Services Unit.....	38
IV. Child Protective Services.....	43
V. Home Studies.....	46
VI. Verification of Information.....	47
VII. Legal Representation of a Child	47
DEPOSITIONS	48
RECOMMENDATIONS	55

PREFACE

The Office of the Child Advocate is mandated by law to review any child fatality or near fatality found to be the result of abuse and/or neglect. Any child or family actively involved or having prior involvement with the Department of Children, Youth and Families (DCYF), or a member of their household are subject to these mandated reviews. These reviews provide the Office of the Child Advocate and the Child Fatality Review Panel the opportunity to review these cases to recommend systemic changes. In January 2019, the OCA commenced the review of one (1) fatality, this report reflects the findings and recommendations of the Panel. I would like to express my appreciation and gratitude to each member for their hard work and commitment. Each member took time from their schedules to assist the Office of the Child Advocate with the review of thousands of pages of documentation and to provide their expertise in the analysis of this case. This comprehensive report would not have been possible without them:

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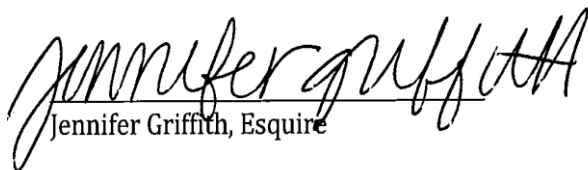
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Thank you to all members of the panel for your continued commitment to improving the safety and well-being of children in the State of Rhode Island. I would also like to acknowledge my dedicated and loyal colleagues, Kathryn Cortes and Katelyn Medeiros, for their consistent diligence and trustworthiness.

Sincerely,



Jennifer Griffith, Esquire

INTRODUCTION

The Office of the Child Advocate (hereinafter “OCA”) is mandated by law to review any child fatality or near fatality where the child was “...in the custody of, or involved with, the [Department of Children, Youth and Families], or if the child's family previously received services from the [Department of Children, Youth and Families].” (hereinafter “DCYF” or “Department”). *See R.I.G.L. § 42-73-2.3*. The OCA also reviews a fatality or near fatality when “[a] sibling, household member, or day care provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months...” *See R.I.G.L. § 42-73-2.3*. Additionally, the OCA reviews any child fatality or near fatality, “...alleged to be from abuse or neglect of the child”. *See R.I.G.L. § 42-73-2.3*.

This report constitutes a public record under Rhode Island General Laws 30-2-(d)(16). This is in conformity with the Office’s confidentiality obligation mandated by Rhode Island General Laws 42-73-1 et seq.

The information contained in this report is the result of an investigation and thorough review of DCYF documents, police and fire reports, medical documents and community provider documentation. The purpose of this report is to review the systems currently in place at DCYF and recommend any changes needed to ensure the safety and well-being of all children within the child welfare system. This review encompasses the death of nine (9) year old “A” and her adoptive mother, FM over the course of thirteen (13) years.

The panel reviewed the following records and documents: the RICHIST notes from DCYF, the hard copy files from DCYF, the police and fire records from the municipality where the family lived and the records from service providers associated with this family. School Department records were requested from the municipality, however were not received by this Panel. The Office of the Child Advocate also requested a copy of the Department of Administration’s Human Resources report which evaluated the actions of DCYF personnel regarding this case. This request was denied by Director Piccola, who cited that this report contained personnel information, was confidential and was not subject to disclosure. During the Department’s press conference on April 12, 2019, Director Piccola discussed the disciplinary actions imposed upon DCYF employees who had been involved with this case. She said, “three people were no longer employed by this Department.” The Office of the Child Advocate requested the names of these three individuals from the Department. The Director did provide the names, however, it was confirmed in writing

that “these three individuals did not leave as a result of this case. They previously left state government.”

EXECUTIVE SUMMARY

The information enclosed in this section has all been taken directly from DCYF documentation, medical records and service provider information. Direct quotes and language used are that of DCYF personnel and reflect the information each worker submitted into the record system known as RICHIST. Names in this report have been changed and all children in this report are identified by a letter to protect the confidentiality and best interests of each minor child. Any identifying information either by name, date of birth, address etc... has been removed from this report.

Foster Mother (FM) came to the attention of DCYF in **2007** when she became the legal guardian of her two grandsons ages five (5) and three (3). Prior to FM becoming the children’s guardian she was required by the RI Family Court to complete the DCYF licensing process to foster these children. This process requires a criminal background check, fingerprinting and a BCI. FM’s criminal record contained information that disqualified her from becoming a licensed foster parent. FM appealed this decision with DCYF and it was overturned, allowing her to become a licensed kinship foster parent through DCYF for her two grandsons only. She subsequently became the children’s legal guardian and her case closed to DCYF.

In **2011** FM re-applied to become a foster parent. FM initially wanted to foster teens at risk of aging out of the system but decided caring for infants and preschoolers, particularly Immediate Response placements would be a better match for her and her grandsons. FM feels she can provide love and stability for other young children in the foster care system. FM describes her motivation to be a foster parent, “I have ‘extra’ to share- extra love, extra space, extra time,...just ready to do this.” DCYF’s updated clearance dated 03/10/11 shows the prior kinship provider licensing record. BCI Clearance dated 03/10/11 shows no criminal record for FM in Rhode Island. Fingerprint results dated 02/08/11 show the following convictions: Possession of a Controlled Substance in 1982 in Indiana (received a suspended sentence); Receiving Stolen Goods in 1983 in Indiana (served a year in prison) and Larceny in Florida in 1993 (received probation). FM appealed the

automatic bar to foster care licensure related to this information at the time of her application for kinship foster care. The initial denial of her foster care application (2007) was overturned by DCYF through administrative appeal on 09/14/07.

The DCYF hearing officer advised that FM had demonstrated a long-standing record of excellence in child care with letters from her daughter in Oklahoma, from her mother and from her grandchildren's day care and preschool provider. DCYF Hearing Officer stated, "After careful review of the disqualifying information as provided by the Department as well as letters of recommendation submitted in your behalf, I am removing the automatic bar to your kinship license." The references submitted were from family members that FM had not seen or lived with for many years.

FM completed pre-service training for foster and adoptive parents through the Urban League in **May 2011**. FM completed kinship training through DCYF in **2007**. FM expressed being open to having a child from infant to age one (1) of either gender placed with her, but she flexible about the age range. FM expressed willingness to take a child who has mild to moderate medical problems such as Cerebral Palsy, asthma and allergies. She is also open to caring for children with developmental disabilities including Downs Syndrome and children on the Autism spectrum. FM appreciates the importance of support services and is willing to utilize any home based or other services needed for children placed with her. FM is willing to be an Immediate Response foster home and completed the required trauma training at Case Family Services in April 2011. She is also open to long term foster care placement and is willing to be a permanency resource for any child placed with her. FM's application to be a generic foster home was approved.

July 27, 2011, "A" age two (2) was placed in the foster home of FM.

"A" was diagnosed with Hydrocephalus in utero at 5 ½-6 months of pregnancy. "A's" birth weight was 5 lbs 2 oz. "A" was transferred to Boston Children's Hospital (BCH) on the sixth day of life. "A's" diagnosis: Hydrocephalus, congenital aqueductal stenosis, Failure to Thrive (FTT) and moderate umbilical hernia. While at BCH "A" underwent EVD (external ventricular drain) and then one month later needed an internal surgery for a ventricular shunt. "A" is also diagnosed with agenesis of the corpus callosum. "A" has reactive airway disease treated with albuterol prn and

also suffers from febrile seizures. “A” is noted to be dependent in all areas of daily living. “A” is able to participate with bathing, dressing and diaper changes. Previous caregivers report “A” is able to finger feed self and is on a regular diet. “A” eats all textures and tastes of foods and is able to drink from a sippy cup.

At approximately age 3, “A” was evaluated by Solutions CEDARR to develop a Therapeutic Integration Plan. Although “A” could not walk independently, “A” was able to use their arms to move their body across an open area. “A” is able to sign several words and speak some words. Current FM reported concerns with “A’s” vision and “A” was due to be scheduled for eye surgery in the future. “A” has weakness on the left side and should be encouraged to use this side to build strength. “A” has a history of "staring seizures" and has seen a neurologist. “A” has been prescribed Nasonex and a nebulizer for asthma. “A” is on a special diet but experiences frequent stomach aches. FM reports that spoon and fork feeding is difficult due to “A’s” vision issues.

November 2011, “A” was evaluated by a neurologist in the pediatric neurosurgery clinic at RI Hospital to for a follow-up due to their shunt. FM reports that “A” is making slow and steady progress. She has not witnessed any repetitive or jerking movements, no staring spells, has not turned blue, no headaches, seldom irritable and sleeps well through the night. “A” has not shown any difficulty chewing, swallowing, or choking easily. FM was educated on the shunt, hydrocephalus and the signs of shunt failure.

December 2, 2011, “A” is reportedly having difficulty with feeding; “A” is “pocketing” food in their mouth.

January 3, 2012, “A” is evaluated at Hasbro Children’s Hospital for feeding problems, weight loss and constipation. Child is not gaining weight. FM began adding a supplement in cow’s milk; child was previously taken off dairy due to causing significant eczema. “A” has failure to thrive and weight loss. A significant problem is how long it takes to finish a meal. FM believed she was following medical advice by giving child juice and water to maintain hydration. FM only recently started giving her carnation instant breakfast as she didn’t seem aware of the seriousness of the failure to thrive. It is also not clear how well hydrated she is. Child may need a feeding tube as it

is unclear how much she is taking in. WIC form filled out for Pediasure. Noted that if the child does not gain weight by next appointment she will need an in-patient hospital evaluation.

January 5, 2012 Child "B" age three (3) months old is placed in the home of FM. As an infant, "B" was diagnosed with GERD and eczema and hospitalized for a short period to address an RSV infection.

January 6, 2012, follow-up evaluation for Child "A" at Hasbro Children's Hospital for failure to thrive and feeding problems. FM reports that she's been keeping the child in the high chair all day long to feed her. She reports child has congestion most of the time. "Given the length of time it takes for "A" to eat and the fact that the foster mother now has a new young foster child in the household, it's not clear if her current regimen is realistic. FM reports she kept child in high chair all day to feed her and achieve weight gain over the past few days. Practically and developmentally this is not a good plan. FM left the visit without getting the child's bloodwork done."

In **April of 2012**, the biological parent of Child "B" expressed to the Department that "B's" FM is too busy with her two grand-children and other young foster child who has special needs to give "B" the attention necessary. Parent expresses wanting "B" in a foster home where "B" would be the only child."

In **May of 2012** a progress summary was completed by Meeting Street for "A's" Early Intervention (EI). It is noted "A" has made great gains with speech and language skills since starting with EI. "A" is using words independently to communicate and gestures. Child also can understand simple instructions. Child will need continued work at home and at school to develop speech and communication. "A" will transition to school special education services. It is highly recommended that "A" continues with speech-language therapy within the school placement. Communication between the school and home will be important to help with continued development and ensure carry-over of skills addressed and acquired within school-based services. At this point "A" is noted to be walking between her mother's legs but mainly gets around by scooting on her bottom or crawling. "A" is feeding herself independently with finger foods and

can drink from a cup independently through a straw. Due to a nystagmus in her eyes, progress has been impacted.

May 2012, DCYF picked up “B” for a two hour visit with biological mother. FM was very upset towards the worker because “B” was having a visit with biological mother. DCYF notes, “FM was also abrupt in her speech when she stated, ‘this is ridiculous and this shouldn’t be happening.’ FM went on to say, ‘It’s not fair, this is my baby’, and she began to cry. FM repeated ‘this is my baby’ several times. DCYF reminded foster mom of her role as a foster parent. FM said ‘I know, I say too much.’ FM mom bent over to say good bye to “B” and turned around and she was crying. Upon return to FM from the visit, FM was sitting outside and immediately came to the car and took the car seat from the car. FM said, ‘this is ridiculous, I’ve been (motioned biting her nails) the entire time he was gone. FM presented angry and continued to say ‘I don’t understand this’.

May 2012 “A” was seen by primary care physician for a developmental check. Doctor recommended “A” have a G-Tube put in to assist the child with better nutrition and to free up time to work on other developmental activities. Child has only gained some weight and FM spends the day trying to get her to eat. In June 2012, “A” had eye surgery at Hasbro Children’s Hospital to correct the condition exotropia with bilateral inferior oblique muscle. A couple of weeks later “A” is seen by the pediatric gastroenterologist due to failure to thrive. FM reports “A” is difficult to feed and “is playing tricks”. FM is leaning towards a g-tube especially since there are issues with the other foster child in the home who will likely need cranial surgery. Doctor advised a g-tube may be beneficial due to “A’s” slow weight gain and feeding refusal. On September 4, 2012 “A” was again seen by the pediatric gastroenterologist as a follow up from poor weight gain. “A” had been having Boost and “A’s” weight significantly improved.

September 7, 2012, child “C” was placed with FM at age three (3) days old. In March 2013 a conversation between DCYF and FM takes place in reference to “C” reunifying with biological parent.

FM knows “C” is going home soon. FM states she took “C” out of the hospital at 3 days old and FM is very attached to “C” but understands reunification with biological mother. FM has already contacted the DCYF placement unit to request another child. FM advised DCYF told her there is

a premature baby in the hospital that could go to her if “C” or any other child goes home by the time the premature baby is ready to be discharged.

On November 7, 2012, Biological mother of child “B” meets with a DCYF Supervisor in the lobby of the DCYF Building. Biological mother reports bruising on “B’s” left leg. Supervisor reports, “The child has some bruising on his upper left thigh. There were four small marks that looked like finger marks, as if his leg was held by someone’s hand. Bio mother also showed me some scratch marks around child’s left ear.” A call is placed to the RI Child Abuse Hotline to report alleged abuse.

Child Protective Investigator (CPI) spoke with child “B’s” biological mother. She reiterated her concerns reported to the hotline. She felt “B” needs to have a second opinion regarding the bruises. Biological mother stated she did not suspect foster mother is abusing her child but is concerned about the level supervision FM is giving her child. She feels one of the other foster children in the home caused the bruising. Biological mother advised this CPI that foster mother is caring for five children and she doesn’t feel that the FM is supervising the children adequately. Biological mother stated once again, she would like her child removed from FM’s care. CPI spoke with assigned DCYF worker who did not suspect any incidents of abuse or neglect by the foster mother. DCYF Worker was updated by the Investigator with respect to the investigation and advised there is no indication of abuse or neglect at this time.

November 14, 2012 at approximately 9:27 PM, the Child Abuse Hotline received a phone call FM called 911 because “A” had a seizure. FM said child had not been feeling well at day care and at home. Child has been with FM for 18 months. FM has four other children and cannot accompany “A” to the hospital. DCYF worker confirmed doctors are doing tests to determine if there is concern with “A’s” shunt. “A” is reported to have a second seizure around 2 AM but it was much smaller. The doctors reportedly believe that it is viral but are still doing tests. “A” was discharged to FM and a few days later “A” is reportedly eating well and looks great. Approximately one (1) month later in December “A” had another seizure. Child was transported to the hospital and during an abuse screen the hospital noted that in the EMS report it said that upon arrival to the home “A” was on the floor naked and cold. FM stated she was feeding ‘A’ in the high chair and noticed child

having a seizure, so FM placed “A” on the floor. “A” did not require hospitalization for this seizure. Biological mother of “A” reached out to the assigned SW for “A” and requested SW attend all medical appointments due to issues between FM and Biological mother. Biological mother informs worker she does not feel comfortable to be alone with FM due to her behaviors. SW explains to bio mother it “would be almost impossible” for SW to attend all the appointments “A” has.

In **December of 2012**, biological mother of Child “B” once again contacts DCYF and stated with everything going on, she doesn’t find that the foster home in which “B” resides is safe. She feels FM touched “B” and she can’t let the bruises go and “I believe that my “B” is being hurt.” Biological mother stated that “B” is not playful and when “B” was in her care, “B” was laughing, playing, talking and almost crawling but since being in this foster home, “B” has declined. She doesn’t believe “B” is getting the one-on-one attention needed because FM has other disabled children in the home and “B” doesn’t get undivided attention. Biological mother believes “B” has had problems since going to this home and is not around people who are normal. Bio mother once again requested child be moved. Biological mother stated she has a sister out of state she would like to care for “B”. She wants “B” with a family member and where she knows “B” will be safe. It is noted by DCYF in February, March, April, May at each home visit “B” is sitting in a high chair. In February and March “B” is wearing only a diaper. “B” is diagnosed in motor skills and has cognitive delays.

In **January of 2013**, “A” is seen by the pediatric gastroenterologist for a follow up evaluation due to failure to thrive and feeding problems and the Neurology department with respect to the seizures from the month before. The Neurology team feels due to the unprovoked seizures and the risk of recurrence being high “A” is started on seizure medication. The pediatric gastroenterologist notes FM feels “A” needs a feeding tube. Previously, FM was enthusiastic about oral feeds but now due to weight loss FM is seeking the feeding tube. According to the doctor’s notes, it takes a very long time for the child to eat and FM stated, “there are other special needs children in the home that require significant care and attention.” In February, FM brings “A” to Hasbro Children’s Hospital for a specialty appointment and follow up however, she leaves prior to the child being seen by the doctor because she needed to attend to her other foster children. FM reports she has in-home support services but is in need of respite. The hospital’s family coordinator provided FM with an

application for respite services and acquiring support for the family. FM did not provide this information to DCYF nor did she follow up with any respite services. In a follow up visit with the gastroenterologist in April FM reports “A” is refusing to eat and wants to live on “Boost”. FM reports due to the difficulties feeding “A” FM must put the child on her back in to get her to swallow food. “A” was supposed to have an appointment with a psychologist on this same day and advises the doctor FM canceled it due to believing the child’s biological parent would agree to the feeding tube and the psychologist appointment was unnecessary. The doctor explained to FM even if “A” gets the G-Tube “A” will still need to see the psychologist for feeding refusals worsening. Patient is only drinking Boost and FM is taking measures to get her to swallow pureed foods such as lying “A” down. FM was counseled against this to prevent aspiration. “A” was seen again in October by Hasbro Neurology due to current diagnoses. FM indicates “A” is up all night talking and singing and is tired during the day. Feeding and weight gain continue to be an issue.

In April 2013, the Social Worker of child “C” reports FM was very upset because this worker did not confirm a visit with her. FM stated she was tired of working with DCYF. It is not the first time FM expressed to being tired of dealing with DCYF. A few days later “C’s” biological mother notifies DCYF that FM contacted her and stated she was picking “C” up early from their visit. FM was crying and saying that biological mother would have problems taking care of “C”. Biological mother expressed she was not happy with FM’s comments about taking care of “C” and should not be changing their visit time without good reason. Social Worker advised biological mother the case would be reviewed it is the hope FM would receive 10 day notice that “C” is going to be reunified with biological mother. This foster child was reunified with biological parent in May 2013.

May 7, 2013, baby “D” is placed in the home of FM. At this point FM requests an increase in her foster care license to allow for more children. A Foster Re-License application is completed and submitted to DCYF. In this re-licensing packet FM submits all of the same information she supplied during her 2007 and 2011 licensing applications. FM only submits three (3) of the four required references and two (2) of these references were immediate family members. The final reference submitted was the foster children’s pediatrician. The first home visit by DCYF for baby “D” is June 10, 2013. Foster placement presently has five children living in the home, two of FM’s

grandsons the other three (3) are foster children. FM informs DCYF baby "D" at one (1) month of age has met a few milestones such as eye contact and follows FM's voice when she moves from one spot to the other. FM advises DCYF she has met baby "D's" biological mother and is trying to develop a trusting relationship until something happens where FM feels she needs to stop it. FM informs at this time the one (1) month old baby gets up once during the night to be fed and FM has the baby on a structured routine and does exceptionally well with it. Approximately two (2) weeks later FM informs DCYF one (1) month old baby "D" sleeps through the night with no difficulty. Biological parents of "D" requested placement of "D" with family members and/or friends on numerous occasions.

In **August of 2013**, FM came under investigation by DCYF after being informed by the Department of Health WIC Division she was selling "A's" prescription formula on Craigslist. The Department of Health advised "A" is diagnosed with Failure to Thrive, CP and numerous other medical conditions. This is a very specialized formula and should not be given to other children without a prescription. A DCYF investigator interviewed FM and discovered she had not yet sold the formula and she was unaware she could not sell it on Craigslist and this was all a misunderstanding. FM agreed to return the unused formula to the Department of Health. A representative from the Department of Health advised DCYF FM needs to be made aware should this happen again it could be deemed a federal offense.

On **September 13, 2013** siblings Child "E" and Child "F" were placed in FM's home. On September 25, 2013 FM's foster care license was increased to five (5) foster children. At this time FM has seven (7) children in her home. Approximately one (1) month later FM requests the removal of child "F" as she feels "F" is hurting the other children in the home and is a significant behavioral problem. DCYF was informed "F" had threatened to run away and had disclosed to school personnel "F" is being locked in a room by FM. There was no follow up by DCYF regarding the allegations of being locked in a room and "F" was removed from this home.

On **October 23, 2013** three (3) month old baby "G" was placed in the home of FM. The first in home visit conducted by DCYF in January of 2014 seven (7) month old baby "G" is sitting in a high chair playing with toys. Baby is reported to be in a "high chair" in February, March and April.

In April "G" is noted to be wearing only a diaper. FM expressed a desire to adopt "G" should reunification not happen. "G" has significant delays and is unable to speak or communicate. "G" has ankyloglossia (tongue-tied) and strabismus. In November 2014, a termination of parental rights was granted. In March 2015 an Adoption Home Study was completed by DCYF for this child. Documentation has proven the same foster care/adoption home study information from 2007 and 2011 was used to complete this study in 2015. The only updated changes provided was the adopted child and two (2) current foster children also in the home. There were no specific details regarding the significant disabilities or needs of the other minor children living in the home. "G" is adopted by FM in April 2015 and "G's" case is closed to DCYF.

November 2013 assigned DCYF SW made an unannounced home visit to FM to visit child "E" due to being unable to get in touch with FM. Upon arrival of SW, FM verbalized being unhappy that SW was there as FM responded to SW via email regarding a visit. SW reports, FM did not want SW in the home and this was evidenced by FM only opening the door a crack. SW requested to see "E" and FM verbalized wishing she had more notice as the house was not as clean as she would like. The home was noted to be cluttered but not unclean. SW observed two foster children in high chairs. All future face to face visits with "E" were documented during out of home visits, not in the home of FM. Child "E" was removed from this home in March 2014.

April 1, 2014 Child "H" age twelve (12) is placed in the home of FM. "H's" biological father provided DCYF with two (2) family members that may be able to take and care for "H" in their home. Biological mother also provided the name of a family member and close friend to provide care for "H". Both parents were informed these names would be reviewed. On April 3, 2014 another relative contacted DCYF expressing an interest in caring for "H". This child was diagnosed with oppositional tendencies, anger management, depressive disorder, and possible Reactive Attachment Disorder (RAD)." Biological parents requested "H" to be placed with family members on numerous occasions throughout "H's" time living in the home. This child moved out of this home approximately seven (7) months later.

June 10, 2014, child "B" was adopted, and the case was closed to DCYF. FM has seven (7) minor children living in the home and is identified as providing respite services on the weekend for a

fourteen-year-old, and again at the end of the month for a fifteen-year-old. There are no licensing restrictions for respite care as a respite home does not have to be licensed by DCYF.

July 2014, DCYF places a hold on FM's license due to the number of children in the household. There are currently eight (8) minor children in the home, including her two (2) grandsons, one (1) adopted child, four (4) foster children and she provides respite care. During this month FM placed a call to the Child Protective Services Hotline to report "A" had a severe seizure lasting longer than five (5) minutes. Once the child entered the five (5) minute mark, FM called the rescue. FM advised due to the fact she has eight (8) children placed with her she is unable to accompany "A" to Hasbro Children's Hospital and will need DCYF to transport the child back to her home once cleared from the hospital.

October of 2014 concerns are brought to the attention of the Department by a CPS worker assigned to a case regarding two children in the home. The allegations in this investigation did not involve FM. The CPI involved in this case contacted numerous DCYF workers involved with the FM and children in her home. It was stated, "When I arrived to the home, FM was attempting to get dinner ready for the 6 children. The 3 littlest were in cribs crying and waiting for FM to pick them up. Given the ages of the children this is the only way she can prepare dinner or do anything while the children are awake. Which seems like a good plan but I don't think it is appropriate just because we have placed too many children with her that are so close in age that require a lot of attention. I know her grandchildren attend counseling once a week and the young children wait in the van during the appointment with her. I definitely think the number of children is a safety concern given she doesn't have a lot of support." Other assigned workers did not share the concerns brought forward by the CPI and all children remained in the home. No additional supports or services were provided by DCYF for FM or the children.

During the month of **October 2014**, "A" was seen by the Hasbro Children's Hospital Neurology team for the follow up of a seizure from July 2014. Prior to the seizure in July, "A" had not had a seizure since 2012 after being prescribed medication for epilepsy. Doctors note, "A" is making gains in all areas: using multi word phrases and walking with the assistance of a walker. Child is in all day kindergarten in the public-school system and has supports during the day. "A" has an IEP and a 1:1 staff person assigned to assist with daily tasks. Child currently lives with seven (7)

other children and there is one more foster child on the way. Weight gain is improving. Also, in October the biological parents of child “D” requested this child be placed with a family member currently providing care for a sibling of “D”. Approximately one (1) month later DCYF visits “D” in the home and “D” is “strapped in a chair watching TV.” There is question if “D” is autistic.

In **April 2015**, DCYF social worker requests DCYF Licensing Unit to allow a variance for FM to take in another foster child. On April 15th biological sibling of “D” is removed from the current foster home and is waiting in the lobby of DCYF for the variance to be approved. The variance was granted later that day and baby “J” sibling of “D” was placed in the foster home of FM. DCYF documents, “variance granted to allow placement of 6 month old sibling of child in the home. There will be 5 children under 6 and 3 children under 2. Variance to expire in one month when child turns 6. Another child will turn 3. The termination of parental rights was granted by the Court for the biological parents of “A”. The Adoption Home Study was completed by DCYF for “A”. FM’s full history was not documented in this home study nor was there detailed information pertaining to each child living in the home. “A’s” medical history was missing vital information in the report and failed to provide an accurate depiction of the significant needs of “A”. In June 2015, “A’s” assigned DCYF worker engages in an email conversation with FM after concerns of hoarding arose. The subject line of the emails is “FM the semi hoarder” FM states, “I feel bad...you know I love my girl to the moon, right? I don’t want you to feel she isn’t in good hands.” DCYF worker responds to FM, “You need some RELAX pills. Your not the worst hoarder LOL. I am not worried.” This ends the email correspondence and there is no further information regarding these concerns noted by DCYF. In March 2015, an Adoption Home Study was completed by DCYF for this child. Documentation has proven the same foster care/adoption home study information from 2007 and 2011 was used to complete this study in 2015 and the address submitted was where FM lived in 2007. “A” was adopted in November 2015 and “A’s” case closed to DCYF.

A re-licensing visit was conducted in **August 2015**. FM reported she works from home as a self-employed Operation Manager and is currently caring for two (2) adopted sons, three (3) foster girls and her two (2) grandsons whom she has legal guardianship of. The home was noted to be clean but somewhat messy. The two (2) adopted boys share a room, the three (3) foster girls share a bedroom and the two (2) grandsons share a room. This home was recommended for re-license for three (3) children between the ages of 0-18 years, female gender only.

In **October 2015**, child “D” is adopted. An Adoption Home Study was completed by DCYF. Documentation has proven the same foster care/adoption home study information from 2007 and 2011 was used to complete this study for this specific child. There were no specific details regarding the significant disabilities or needs of the other minor children living in the home. Shortly after this adoption, the DCYF licensing unit reduced FM’s foster care license to two (2) children. Licensing documents, “FM is at the capacity of having 7 children in her home under 18 as a single parent. Was licensed for 3 children, she now will be licensed for 2, as she adopted one of her foster children.” One month later in November, “A” was adopted by FM and her license was again reduced to one (1) child. FM understood she would need a variance to allow an eighth (8th) child into her home. At this time there are seven (7) minor children living in the home. “D’s” case closed to DCYF.

In **February of 2016**, FM purchased a larger home for her and all the children to live in. FM advised DCYF the layout of the house makes it far more accessible and easier for her adopted child in a wheelchair. This home also provides better logistics for watching all the children at the same time. They would be always in clear sight. FM is currently caring for seven (7) children at this time: one foster daughter, “J” age two (2), four (4) adopted children; “B” age five (5), “G” age three (3), “D” age three (3), “A” age seven (7) and two (2) grandsons ages eleven (11) and thirteen (13) of whom she has legal guardianship.

FM occupies her own 300 SF bedroom. “A” occupies a single room. “G” and “B” share a bedroom. Two grandsons share a bedroom. “D” and “J” share a bedroom. The home appeared to be properly child proofed, clean and neat. There were no safety concerns at this time. It was recommended by DCYF licensing to license this home for (1) child only to accommodate foster child “J” already living in the home.

In **June 2016**, the biological mother of “D” and “J” gives birth to a baby. FM is made aware of the birth and expresses a desire to have infant placed in her home. FM advises her bedroom is big enough to support a crib. DCYF is requested to provide a variance to allow an eighth child into this home and to allow for the maximum number of children by a single parent to be permitted. A few weeks later infant “L” is placed in the home of FM. Concerns around FM’s ability to care for an additional infant are raised by some DCYF workers however, FM has the backing and support

of the assigned SW and Supervisor to place infant “L” in the home. FM advised she is aware of services in her community if needed and the church is an outstanding support system. FM also identifies a friend and neighbor that come to the house often and help her out. DCYF did not verify any of the supports FM identified nor did they run any clearances to determine if they would be appropriate caretakers with no disqualifying information preventing them from helping with the children and placed the infant in the home. An email sent from the Licensing Director to a subordinate stated, “I know there were some concerns by other workers, but given the fact that there are kin in the home, and FM ability to house and care for all the children- I believe it was the most logical, and best option for the child.” Currently there are eight children in the home. Infant “L” one (1) month old, foster child, “J” age two (2), four (4) adopted children, “B” age five (5), “G” age three (3), “D” age three (3), “A” age seven (7) and 2 grandsons ages eleven (11) and thirteen (13) of whom she has legal guardianship.

DCYF attends a home visit approximately one month later and reports “J” and “L” to be doing well. Worker observed the other children in the home and reported the older child recently had an extensive surgery and was “propped up with an intravenous connected to the child”. Worker reported all children looked well. This worker continued to visit “J” and “L” in the home however there was no further mention of the other children living in the home and no concerns noted for “J” and “L”.

January 2017, concerns surrounding “J” being Autistic are raised. In February the diagnosis of Autism is confirmed. According to FM, “L” age seven (7) months is showing signs of delays. On March 31, 2017 “J” is adopted. The documentation presented has proven the same foster care/adoption home study information from 2007 and 2011 was used to complete this study for child “J”. Currently there are eight children in the home. Foster child “L” eight (8) month old, adopted child “J” age three (3), adopted child; “B” age five (5), adopted child “G” age three (3), adopted child “D” age three (3), adopted child “A” age seven (7) and 2 grandsons ages eleven (11) and thirteen (13) of whom she has legal guardianship.

In **November 2017** the DCYF licensing Unit documents a re-licensing visit that took place in **August 2017**.

“The license has been pending since 8/31/17 due to a delay in obtaining a lead certificate of conformance. FM reports she works various hours from home as a self-employed Operation Manager. FM is currently caring for 1 foster boy, 2 adopted sons, 3 adopted daughters, and 2 grandsons of whom she has legal guardianship.

On 6/29/16, Administrator issued a variance for this provider to have a total of 8 children under the age of 18 to facilitate placement of a newborn child that is a sibling to 2 of FM’s adopted children. License will close after this sibling is adopted.

Grandson age 13 is in the 7th/8th grade and is doing well. FM is homeschooling him. He is high-functioning autistic and has a therapy dog. He also attends counseling and gets along with the younger children and is especially close with the foster boy “L”. No issues.

Grandson age attends 7th grade at a school and is doing well. He has been diagnosed with anxiety and depression and is on medication. He also has ADHD and was recently diagnosed with mild Reactive Attachment Disorder. He sees a counselor and is followed by a neurologist/behaviorist. He is doing well in general.

Adopted child “B” age 5 has delays and psychiatric issues. “B” receives speech, occupational, and physical therapy. According to FM, 2 weeks prior to this home visit, “B” had some severe behaviors. “B” pulled out his own 2 front teeth, scratched his own arms and pulled out his hair. His behavior was stabilized and FM scheduled an intake with the outpatient services. FM is looking to put “B” in a psychiatric pediatric-partial school program. FM described him as a smart little boy and is determined to get him the services he needs to succeed.

Adopted child “G” age 3 currently stays at home with FM and is being homeschooled. He has had surgery to correct ankyloglossia (tongue-tied) and strabismus (crossed eyes). He has significant delays due to being born severely drug dependent. He can neither speak nor communicate with sign language. He received speech therapy and is seen by the Children’s

Neuro Development Center at Hasbro. He has trouble regulating his emotions and sometimes throws tantrums when he doesn't get his own way.

Adopted child "A" age 8 was adopted on 11/12/15. FM homeschools "A" and told this worker that she is in the 2nd grade. "A" has significant delays, vision loss, hearing loss, and seizure disorder. "A" gets occupational, physical, and speech therapy and receives in home services. "A" is wheelchair bound. FM reported that despite her setbacks, she is a happy child that loves to watch the other children play even if she cannot participate fully. She enjoys going to the other kids' sporting events.

Adopted child "D" age 4 (DOB 5/2/13) currently stays home with FM who is teaching her pre-k skills. "D" is autistic and has ADHD. FM described her as a fearless busy little girl; FM is in the process of obtaining a therapeutic bed for her as she loves to get out of bed and get into mischief. "D" is saying some words and is learning to regulate her emotions. She is also working on toilet training and fine motor skills. "D" will be getting home based services.

Adopted child "J" age 3 is "D's" sister and currently remains at home with FM. "J" is also autistic and gets speech and occupational therapy through Early Intervention. "J" has sensory issues and won't eat unless her food is pureed. "J" is involved with the feeding team at Hasbro. "J" gets frustrated and screams because she cannot effectively communicate her needs and feelings. "J" is also learning pre-k skills and working on fine motor skills.

Foster boy "L" age 1 is "J" and "D's" biological sibling and has been placed in this home since 6/16. "L" is smart, healthy baby, big for his age that eats and sleeps well. "L" is pulling himself up and walking a few steps. He is working with Early Intervention for balance issues. DCYF Worker reported that "L" is doing well and reported no concerns with this home. FM will be adopting "L".

All eight children were present at the time of this visit and appeared happy, healthy and well cared for. FM owns 2 dogs that are up to day on their rabies vaccination.

“L” slept in FM’s room until age 1. FM put him in the 108 SF bedroom so all the little boys would be together. There is space in grandsons bedroom. Licensing worker approved of this sleeping arrangement on 11/15/17.”

This information was provided through the Licensing Unit for re-licensing purposes due to foster child “L” in the home, there was no follow up from DCYF to verify any of the information gathered during this visit. There was no follow up to determine if FM had the ability and supports in place to deal with all the documented medical, psychiatric and behavioral issues of all the children living in the home. No assessment was completed to determine the safety of each child in the home, nor was there confirmation of the supports systems identified by FM. Regardless of the lack of verification, safety assessment of the children, or an assessment to determine if FM is capable of managing all the children and their significant needs, licensing recommended this home be re-licensed to allow the one (1) year old foster child to remain.

The assigned worker visits “L” every month as required by DCYF policy. There are no concerns noted until January 2018. January 29, 2018, a call is placed to the Child Abuse Hotline.

On **January 29, 2018** CPI is assigned to the following report:

“Yesterday reporter (R) went to the home as her client “L” is in foster care. R said all of the children in the home are disabled to some degree, and the eldest, who might be 11yo or 13yo is Autistic. R said there are 7 children in the home all ranging in age from 18 months old up to the 11-13yo who was in the home alone babysitting.

R said FM left the children home alone for at least 45 minutes. Mo dropped off one of her children and then went to Dunkin Donuts to get coffee during those 45 minutes.”

Upon assignment of this report the CPI contacted the reporter and was advised by reporter the six children had been left in the care of the oldest grandson. The reporter expressed

feeling FM is overwhelmed in the care of the children and given the special needs of the oldest grandchild, he is not capable of caring for the six children. Reporter also advised during visits in this home “L” is observed in his bed or play pen. Reporter visits this home to assist “L” in developing skills needed to walk and suspects some of the issues “L” faces is the lack of opportunity to practice these skills.

CPI responded to the family home and FM was advised of the pending investigation. “FM initially presented as uncooperative stating, ‘I do not have time for this and I will not do this today.’ CPI managed to deescalate the situation and was permitted in the home.”

“The home was observed to be cluttered and out of order, there was a strong order of urine present. FM refused to allow CPI access to the 2nd floor bedroom area, rather instructed oldest grandson to carry the children one by one downstairs. The children “B” (6), “D” (4), “G” (4), “J” (3), “L” (1) were observed to be dressed in a diaper only. No marks or injuries were observed on any of the children. The child “A’s” bedroom is located on the 1st floor, oldest grandson was instructed by FM, to move her from her bed to wheel chair and bring her into living room. “A” has significant medical and neurological issues, “A” is non-verbal.

-Face to Face contact with “B”, “is 6 years of age & DD. Was observed wearing a diaper, no marks or injuries were observed.”

-Face to Face contact with “D”, “is 4 years of age & autistic, was upset and crying. Was observed to be wearing a diaper, no marks or injuries were observed.”

-Face to Face contact with “G”, “is 4 years of age & DD. Was not interested in talking with CPI. Was dressed in a diaper, no marks or injuries observed.”

-Face to Face contact with “J”, is 3 years of age and Autistic. Dressed in just a diaper- no marks or injuries.”

-Face to Face contact with “L”, “is age 1, non-verbal w/ DD. Dressed in just a diaper- no marks or injuries.”

-Face to Face contact with “A”, age 8 significant DD, non-mobile -uses a wheelchair, no marks or injuries.”

CPI met with the oldest grandson (14), who appears high functioning. He described that he routinely watches the children while his mother run errands. He states if there was an emergency he would call his mother or 911.

FM’s other grandson appears healthy and well cared for. He is in attends school outside of the home. He reports feeling safe and cared for at home. FM reports he is having issues with Anxiety, noting she recently brought him to the Hasbro ER for an emergency evaluation, where they remained for 6 hours.

FM admits she at times leaves the children with her oldest grandson, for short periods of time while she for example runs to the store. CPI expressed concerns given the fact that the six children presents with developmental issues. FM defended her decision pointing out that the children are secured in their beds when she leaves them. CPI states there is still concern as if there were for example a fire, oldest grandson would not be capable on his own to get the children out of the home.”

CPI met with the assigned DCYF worker for “L” and this worker expressed no concerns for “L” and states FM always meets “L’s” needs. CPI also met with a Licensing Supervisor to discuss and review CPI’s concerns. This investigation was Indicated for findings of Neglect by FM. FM continued to defend her decision to put her 14-year-old grandson in the role of caretaker. This case was referred to and hand delivered to the Licensing Division for Regulatory Review.

There is no documentation that the Licensing Department conducted a home visit to follow up on the regulatory issues of this foster home. Documentation from the licensing division occurred on

April 5, 2018 and stated, "Indicated for Neglect...FSU is still planning on going forward with this last adoption. Provider is most likely closing after that adoption. All children in home are special needs and mother leaves her Autistic son in charge when she needs to leave."

Social worker for "L" met with FM in her home on February 16, 2018 and "L" was smiling and appeared healthy. FM expressed concerns regarding the ongoing investigation as she had not yet been advised of the outcome. Worker advised FM had spoken with a Supervisor prior to this visit and FM's case with "L" remains status quo. FM advised she was going to be moving her mother into the home within the next few weeks as her mother was selling her home in Florida. FM was advised she was Indicated for Neglect on this day.

March of 2018 assigned worker for "L" attends a visit in the home of FM. FM informs worker her mother will not be moving into the family home. FM reviewed the fire safety plan with worker and advised her oldest grandson will be responsible for "D," and the two boys ("B" and "G") and FM will get "C" and "L" and they will all meet in the backyard. There is no mention of child "A" who is wheelchair bound and child "C" was noted to be reunified with a biological parent in 2013. The last documented in home visit by worker for "L" is in April 2018. Worker had scheduled a meeting in June with FM, however FM stopped by the DCYF office on this day instead. Worker documents "L" looks well cared for and FM was given the adoption disclosure. "L" was adopted one month later in July 2018 and the case closed to DCYF.

On **July 2, 2018** two weeks before the adoption of "L" the Licensing Unit documents, "Monitoring call regarding supervision of children in the home. Foster mother stated that her mother comes over to baby sit when she needs her."

This Licensing SCWII is very concerned for any future children placement in this home. Foster parent assured Licensing SCW that in the future she will not leave her son with any children under 6 when she will be gone for ½ hour or longer. The Lic SCWII remains concerned regarding FM's down playing the supervision of her adopted children. Her mother is often over and has been helpful in the past and will continue to be able to provide support." "L" is adopted by FM two

weeks later and FM's case closed to DCYF. There is no further contact with this family until six (6) months later in January 2019.

On **January 3, 2019** a call was placed to the RI Child Abuse Hotline:

"On 1/03/2019 the Department of Children, Youth and Families Child Abuse and Neglect Hotline received a report stating the police were called to the home of Adoptive Mother, FM, to assist EMS with a report of an unresponsive 9-year-old-child, "A". She was pronounced dead at the hospital. "

"On 01/03/19 CPI was assigned the above investigation. CPI spoke with Sgt. from the Police Department. Sgt. reported that Adoptive Mother said a bath was drawn for the child, she was put in the bath, and a couple of hours went by before she was found unconscious. Sgt. stated that there is a gap of time unaccounted for. He further stated it appears Adopted Mother relies on her oldest son (grandson) to care for the children. He reported there may be some things going on in the home that do not benefit the children. Sgt. stated he offered to bring Adoptive Mother to the hospital to see the child however she refused and said she didn't want to leave her other children because she was afraid DCYF would take them"

"On 01/03/19 CPI's (two) went to the family's home where Detectives and Officers had arrived and were walking through the home. CPI's observed the home to be in deplorable condition. There were large piles of clothing with food and other objects throughout every room and hallway in the home. It was very difficult to maneuver around due to the clutter. Dozens of medications were left out on the couch, floor, bathroom sinks, as well as a small bag labeled 'medical marijuana.' There was a very strong odor of feces and urine throughout the home. there were dozens of soiled diapers in piles in several rooms. The two bed's in "A's" room were covered in what appeared to be vomit and urine. One of the mattresses was folded backwards and was covered in toilet paper, animal feces and sippy cups. The children's bedrooms extremely cluttered."

"CPI's observed several bags and bottles of medications in the bathrooms. In the upstairs bathroom, there were at least 2 large brown bags from CVS with prescription labels

attached for Oxcarbazepine which CPI learned to be an antiepileptic medication. The labels had "A's" name on them. Also printed on the label was 'Promised: 9/18/18 11:59PM.' Handwritten on the label was 'Only FM to pick up Rx-Check ID*' The bags appeared to be stapled shut and unopened."

"1/3 CPI observed "D" in her home. Mother reported she has a diagnosis of Autism. She was walking around the house and sitting with Mother. Her room was extremely messy and dirty. There were no outward signs of abuse. She was not capable of giving CPI information."

"1/3 CPI observed "B" in his home. He was being silly and showing CPI his Santa hat, calling himself the Grinch. His room consists of a 3 bed bunkbed and he stated he sleeps on the top bed, "G" sleeps in the middle and "L" sleeps on the bottom. "B" told CPI that "A" is his sister and he really likes her and he isn't sure if she is dead. He stated that she went to the hospital but didn't know where she was in the hospital. He told CPI that "A" wasn't breathing and her eyes were closed and that made him feel scared. "B" was examined by the Aubin Child Protection Center and he has an infection on the bottom of his foot which he states may have been from stepping on something sharp. He was given a cream and prescribed an antibiotic. He told CPI his Mother knows about his foot but didn't take him to get it checked."

"1/3 CPI observed "J" in a bedroom upstairs, on a bed that was fully enclosed by a breathable material. There was black marker drawn all over the netting and all over the mattress. The room had toys and objects all over the floor. The child had only pants on. She has a diagnosis of Autism and is nonverbal. There were no outward signs of abuse."

"1/3 CPI observed "L" in his bedroom with his brother "G". "L" had no pants on and his shirt was only half way on, with his arm sticking out. His hair appeared dirty and was covering his face. "L" and "G" were in the bedroom with a babygate blocking their access to the hallway. The lights were off in the room. There were no outward signs of abuse. Mother reported "L" has a 'global delay'."

“1/3 CPI observed “G” in his bedroom with his brother “L”. There was 3-bed bunk bed and the lights were off in the room. The children stood behind a babygate. Mother reported the child has ADHD and Klinefelter Syndrome. The child appeared to have a speech delay and was unable to give CPI any information. There were no outward signs of abuse.”

“On 01/03/19 CPI spoke with Adoptive Mother. CPI asked if all the children in the home have disabilities. She responded that the other kids ‘sort of have disabilities.’ Mother explained that “A” has a diagnosis of Hydrocephaly, Cerebral Palsy and Epilepsy. She denied the child had any recent illnesses or health problems. She stated the child went to the Neurologist about 3 weeks ago and was told she’s okay. Mother reported that she herself had been ill and stated, ‘We don’t touch “A” if we are sick’.”

“She stated her oldest grandson usually puts “A” in the bath as part of their routine. She reported he put the child in the tub at 1:00pm ‘but he will say he put her in at noon because that’s what he was supposed to.’ Mother reported that he came over and they were talking. She told him to give “A” her formula which she drinks from a sippy cup. “A” said ‘Thank you’ when he gave it to her. She reported the child stayed in the tub for about 2 hours because she loves the bath and it helps her hips since she had surgery on them. She further reported that the child is usually okay alone in the bathtub and that she is strong and can get herself in and out of the tub by herself. Mother confirmed the child uses a wheelchair but will also crawl. She reported her grandson had been in and out of the bathroom. Mother reported the child was in the tub for at least 2 hours and her grandson kept reheating the water for her.”

“Mother reported there were about 15-20 minutes between the last time her grandson checked on the child and the time her younger grandson found her unconscious. Mother stated her youngest grandson told her, ““A” isn’t answering me. Something isn’t right!’ She then told him ‘bring her to me.’ Both grandsons placed the child in her arms on the couch and she realized the child was unconscious, so she began CPR.”

“CPI asked Mother if she was planning to go to the hospital and if so, who would be able to come to the home to help with the kids. Mother did not answer, so CPI told her to just let CPI know.”

“CPI asked Mother if she had anyone for support. She stated her neighbor “X” and friend “Y” are supportive. She stated “X” came to the house a little while ago, but the police wouldn’t let her in. It should be noted that an Officer who overheard Mother, told CPI that it was Mother who would not let “X” in.

“Mother told CPI that all the stuff was out and around her home from when they moved. CPI asked how long ago they moved in and Mother stated 2.5 years ago but they never unpacked. She told CPI that this is ‘her spot’ where she does things from and pointed to a pile of clothes near the chair she was sitting on.”

“Mother sat on the chair in the living room for the entirety of time the CPI was at the home. She did not check on her children or get up to speak to anyone walking around the house.”

“CPI explained to Mother that CPI would be removing the children from the home tonight. Mother appeared emotionless. CPI asked Mother if she had anyone who could help her clean the house and she nodded ‘yes.’ Mother filled out the medical consent form for each child. She also signed an obtain and release form for Hasbro regarding “A”. Mother did not get up to get her children ready to leave the home or help pack any belongings. She told her oldest grandson to get the kids’ prescriptions. She sat in her chair while the oldest grandson put the kids’ coats and shoes on. Mother did not have a pair of shoes that fit 2-year-old “L” so he left the home with just socks on his feet. The youngest grandson asked where his basketball jersey was because he had a game on Saturday. Mother did not know where it was.”

“CPI spoke with the oldest grandchild. Child told CPI that there are days the child has day-long baths. He reported he is often responsible for bathing the child. He later told CPI that Adoptive Mother had gone out to run errands that day around 11:00am and he knows she

went to Walmart. He showed CPI that the water went up to his wrist when she was in the tub. He reported the water slowly drains by itself so when he checked on her again at 12:00pm, he added a little more water. Child reported checking on the child again at 2:00pm, then he went to get his siblings off the bus. At 4:30pm, his sibling, found the child in the tub and she was unconscious. The child confirmed the child was alone in the bathtub from around 8:00am until she was found around 4:30pm. He explained that because of "A's" Cerebral Palsy, she cannot keep her legs straight, so she sits in the tub with her legs bent. She was found unconscious on her stomach, with her head to the side."

"CPI met with the younger grandson. He reported he got off the bus around 2:15pm today. He stated that his brother or his grandma get the other kids off the bus typically but today, his brother got them off the bus. This child states he went into the bathroom to check on "A" who was in the tub and found her face down, on her belly, with her head turned to the side. He reported she usually takes a shower but today she took a bath."

CPI spoke with teachers in the school regarding "G", "B" and "D". "G's teacher reported his IEP is overdue because mother missed a couple of meetings. This teacher reports "G" comes to school dirty all the time and this teacher has provided clothes and sneakers to keep at the school to change him into during the day and changes him into his own clothes before returning home. Teacher reports "G" is potty trained; however, Mother puts him in diapers at school. This teacher would "strip him down every day" to check for marks or bruises. Teacher reports he often had blisters on his feet. "B's" teacher reported his progress to be excellent and in conversations with mother nothing stands out. Teacher stated "B" has been much cleaner, has no odor and is at school almost every day. "D's" teacher stated that "Mother told the school the "D" is nonverbal, but she was talking quite well." Teacher further stated, "Mother thought the child needed a communication device and the school called Mother in to show her "D" could talk and color." Mother reported to be happy "D" was potty trained however would send her to school in pull-ups. None of this information provided by the teacher in this investigation had been reported to DCYF prior to this conversation.

On 01/04/19 CPIs met with the two grandchildren to discuss the death of their sister, "A". "The boys reported that their Grandmother's mother is in Florida and won't be around because she doesn't like the kids. They stated she was mean to "G" in February and they haven't seen her since." The oldest grandson was asked what he did for homeschooling. "He described the curriculum as some math, cooking, and caring for his younger siblings and stated "A" practiced crawling and would color. He then stopped and said he didn't want to talk about it.

Based on the evidence reviewed and documented by CPI Adopted Mother was Indicated by DCYF for the following:

Lack of Supervision/Caretaker as to all children

Lack of Supervision/No Caretaker as to "L", "J", and "A"

Inadequate Shelter as to all children

Medical Neglect as to "B" and "A"

Excessive/Inappropriate Discipline as to "B"

Inadequate Clothing as to "G"

Physical Neglect/Death as to "A"

All children were removed immediately and examined by Hasbro Children's Hospital Aubin Center staff.

A thorough review of all police records, fire records and EMS records was conducted and support many of the findings in the 2019 DCYF Investigation. This panel is not reporting on any information contained in those reports as to not impede an ongoing criminal investigation, particularly due to the recent Indictment against FM for Manslaughter.

FINDINGS

I. General Findings:

- Throughout the record it is noted the children are dressed in nothing but a diaper even during the winter. This was documented by service providers and DCYF staff. There was no follow up or notes indicating that this was a concern or that it was addressed with foster mother.

- Throughout the record it is noted when visiting the home, the children were frequently contained in their highchairs. This was documented by DCYF staff and service providers.
- Foster mother admitted to keeping a child in their highchair all day to feed them. The medical provider noted that “practically and developmentally this is not a good plan”. Foster mother admitted to laying this child down to get the child to swallow; the medical professional had to counsel her against this as the child could choke.
- In two of the cases, it is documented that the biological parents of these children had concerns regarding the placement of their children. They requested they be removed from the home. In one case, the biological parent made repeated requests to have the child removed from the home. The parent did not feel the child was receiving the appropriate level of attention or supervision due to the number of children in the home. One parent also believed that their child was being harmed in the home.
- In at least two (2) cases, biological parents identified family members to place their children with. It is unclear what steps DCYF took to effectuate placement with relatives.
- In 2011, a memorandum by a service provider was provided to DCYF and recommended the child be placed in specialized foster home with no pets due to their medical needs. The child was subsequently placed in the foster home under review, which was a generic foster home and foster mother had a dog.
- Medical records for one child reveal that in 2012 the foster child had a seizure, which prompted a response by EMS to foster mother’s residence. Child had to be transported alone and no one was present at the hospital to provide a history of events. Foster mother could not go to the hospital due to other children in the home. The abuse screening at the hospital revealed that when EMS arrived, the child was found laying on the floor naked and cold.
- In 2012, a DCYF worker noted erratic behavior by foster mother when arriving at her home to transport a child. The child had been placed with foster mother for four (4) months. It was documented that foster mother became very upset towards the worker. “[Foster mother] was also abrupt in her speech when she stated, ‘this is

ridiculous and this shouldn't be happening' foster mother went on to say, 'it's not fair, this is my baby', and she began to cry. [Foster mother] repeated 'this is my baby' several times." Upon the child's return, foster mother still presented as angry stating "this is ridiculous" and "I don't understand this". Per the licensing regulations a foster parent must, "support visitation between the child in care and his or her family..." There is no follow up documentation showing that this behavior was addressed with foster mother or prompted a more thorough review.

- In 2012, a call was made to the CPS Hotline. The reporter relayed concerns about bruising that looked like finger marks and scratches on one of the children placed in foster mother's home. The reporter noted foster mother is caring for five (5) children and does not feel the children are being adequately supervised. The FSU worker directed foster mother to bring the child to the pediatrician to be evaluated. The pediatrician determined the bruising would not be uncommon to a child who is trying to walk or crawl. There was no documentation provided, which indicated that the pediatrician was a child abuse expert.
- In 2013, DCYF notes a foster child placed with foster mother had made disclosures to his school he was being locked in a room. There was no CPS investigation initiated regarding this disclosure and no one from DCYF followed up.
- In 2014, CPS and FSU were notified one of the children in foster mother's care having a seizure. The child was transported to the hospital unaccompanied by foster mother due to foster mother having eight (8) other children in the home. Foster mother contacted CPS to notify them that they will also need to arrange transportation for the child to return home. This was the third documented incident where the child was sent to the hospital unattended. There was no follow-up by DCYF regarding foster mother's ability to care for this number of children or the level of supervision being provided.
- In 2015, an FSU Supervisor contacted the Licensing Unit about placing a 7th child in foster mother's home. The FSU Supervisor had the child in the lobby of DCYF. This child is a sibling of one of the children already placed in foster mother's home. Upon receiving this request, licensing notes foster mother has previously requested placement of an unrelated infant but this request was denied. Licensing notes foster

mother has many children in her home and none are scheduled to leave soon. Notes indicate foster mother was alerted to respond to DCYF prior to the Licensing Unit approving this placement. This placement was ultimately approved. There is no documentation outlining if anything was reviewed or considered to ensure the safety and well-being of the child prior to placement in this home.

- Upon review of the record, foster mother cited having too many children as her excuse for being unable to follow through with or attend various appointments and her inability cooperate with service providers.
- Based on the documentation reviewed, the health and developmental progress of the children in foster mother's home declined over time in her care. It was heavily documented that the children were frequently very ill, which prevented their consistent involvement in services and maintaining of important medical appointments.
- In 2017, a service provider involved with this foster family documented they contacted the children's Home School Superintendent. A voicemail was left regarding regulations for special needs children, curriculum and ages for when school begins/ends. There were concerns regarding the education the children were receiving at home. There was no further documentation regarding the outcome of this call.
- DCYF verified pictures of the inside of foster mother's home were sent to a DCYF Supervisor by someone in the community. This Supervisor showed the assigned DCYF social worker and supervisor these photos. It was reported that the social worker was directed to go to the home and fix it. There is no documentation of this information by any of the involved DCYF workers.
- There was faulty understanding of the role and responsibility of all DCYF staff in this case ensuring the safety and well-being of the children in this home. The record reflects the Licensing Unit, Family Services Unit and Child Protective Services deferring issues back and forth to one another without appropriate action ever being taken.
- Inadequate supervision provided by Administrators and assigned Supervisors in the Licensing Unit and Family Services Unit.

- There was failed internal communication at DCYF, within all units, to properly communicate concerns regarding this family. This resulted in a failure to take appropriate action in many instances and left children at risk.
- There was an ongoing failure of DCYF staff to assess risk and the safety of all children in the home.

II. Licensing:

- In 2007, foster mother applied for a kinship foster care license to maintain placement of her two grandchildren. Upon review of her application, the DCYF Licensing Unit denied her application due to disqualifying information, specifically her criminal history. Foster mother was previously charged in 1982 with possession of a controlled substance and received a suspended sentence; receiving stolen goods and was subsequently sentenced to a year in prison. In 1993, foster mother was charged with petty larceny/3rd degree dwelling property and received probation.
- Foster mother's 2007 foster care licensing application presented additional "red flags" including an extensive trauma history with no record of treatment, financial instability and a history of mental health diagnoses. Foster mother also outlines her strained relationship with her mother due to her mother's knowledge of abuse sustained throughout her childhood. Foster mother subsequently uses her mother as a reference for her foster care application.
- In 2007, foster mother appealed the decision to deny her kinship foster care license. This decision was overturned due to her excellence in child care and three letters of recommendation. One by her daughter who lives out of state, her mother and her grandchildren's daycare. Overturning the denial and removing the automatic bar to be licensed by the Department was for a ***kinship license only***.
- In 2011, foster mother submitted an application to the DCYF Licensing Unit to be licensed as a generic foster home. Pursuant to DCYF Licensing Regulations, this application ***should have been denied***. The initial appeal and subsequent overturned decision was for a kinship license only. This appeal continues to be relied upon for each subsequent licensing action.

- In 2011, foster mother's foster care licensing application once again presents "red flags", which viewed in their totality should have prompted the denial of her application. This includes an extensive trauma history with no documented treatment, a criminal history resulting in time served in prison, documented history of mental health diagnoses, financial and employment instability and a tumultuous family history. This includes a strained relationship with one of her application references, her mother. Foster mother notes her mother had knowledge of abuse she sustained by her father and she failed to protect her.
- Foster mother completed pre-service training to be licensed as a generic foster home. Foster mother did not receive any specialized training in the care of children with special needs. Foster mother was not designated as a specialized foster home.
- In 2013, foster mother contacted licensing to increase her license from three (3) children to four (4) children and completed a foster care re-license application. This application required four (4) references but foster mother only provided three (3), two of which were family members.
- The application submitted during the 2013 re-licensing/license process was incomplete and was not updated.
 - Per the DCYF licensing regulations, visits from licensing staff, a new health update and updated fingerprints should be completed.
 - For the 2013 re-licensing application, the physician's reference utilized was from 2011 and the fingerprint results were also from 2011. There is no documentation the licensing worker went out to the home.
 - **NOTE:** Foster mother's re-licensing application and increase to her license was approved four (4) days after the conclusion of a CPS investigation of foster mother.
- In 2013, a couple of weeks after foster mother was re-licensed and her license was increased from three (3) to four (4) children, the DCYF Licensing Unit increased her license again to five (5) children for the placement of siblings. This increase was approved by a Licensing Supervisor. There was no assessment of foster mother's ability to provide an adequate level of care or supervision to this number of children.

- In 2014, a DCYF licensing worker emailed the Chief Casework Supervisor to determine whether to utilize foster mother as a respite home per her request. At this time foster mother has 7 children placed in her home. The Chief Casework Supervisor notes “While we do have concerns due to the number of children in the home, a respite home does not have to be licensed. So whether you use [foster mother] or not is your decision.” There is no additional follow up documented and foster mother was subsequently used as a respite placement.
- In 2014, a hold was placed on foster mother’s license due to the number of children in her home. There are eight (8) children placed with her, one being a respite placement. The Licensing Administrator subsequently reduced foster mother’s license from five (5) to four (4) children.
- In 2015, foster mother went through the re-licensing process. Foster mother failed the fire/safety inspection due to the number of items in the basement. It was noted that foster mother “needs major housekeeping in the basement”. Inspection was conducted again one month later and approved.
- In 2016, the Licensing Administrator and Assistant Director were contacted regarding the approval of a variance to place an eighth (8th) child in foster mother’s home. In making this decision, there is no evidence that the Administration ever:
 - Performed or reviewed an assessment of foster mother’s ability to provide an adequate level of care to that many children.
 - Performed or reviewed an assessment identifying the level of care required for children with such extensive needs.
 - Sent a staff member from the Licensing Unit out to the home prior to granting approval.
 - Foster mother’s willingness to take an eighth (8th) child, an over-reliance on the “requirement” to place siblings together and the Family Services Unit’s advocacy for the placement, were the driving force behind the approval.
- In 2017, the Licensing Unit conducted the re-licensing process for foster mother’s home. The licensing worker performed a home visit and authored a report outlining the information obtained. This report identified the extensive needs of the eight (8) children placed in the home. The level of care that each child required should have

prompted further consideration for the ability of one individual caring for this number of children. Especially in meeting their extensive needs.

- In 2018, a Licensing Administrator was contacted four (4) times by service providers regarding concerns with foster mother. The service provider notified this employee that foster mother was cancelling visits frequently and that foster mother was witnessed to be recording one of their recent visits. When Licensing received this call, there was a pending CPS investigation regarding foster mother. No notes were entered into RICHIST by the Licensing Unit regarding these contacts with service providers. There was no follow up with foster mother or any licensing action taken.
 - Pursuant to the DCYF licensing regulations the foster care provider must be able to meet the “physical, emotional, social, developmental, treatment, educational, cultural and permanency needs of the child in care.”
- In 2018, the Licensing Unit was notified immediately and directly by the Child Protective Investigator regarding the pending investigation of foster mother’s home. This was referred to the Licensing Unit for a “regulatory response” as foster mother was an active licensed provider.
 - The Licensing Administrators never directed any member of the Licensing staff to respond to foster mother’s home to assess the home or the ability of the licensed provider.
 - Pursuant to the DCYF Licensing Regulations, a licensing action can be taken in the following circumstances:
 - The Caregiver failed to “...provide adequate supervision appropriate to the child’s needs and level of development.”
 - “The Caregiver or any household member has child protective services involvement deemed detrimental to the care of the children.”
 - Licensing actions include:
 - Requirement the caregiver attend corrective or in-service training; limit on the number of foster and/or pre-adoptive

children placed in the home; or the revocation of their license.

- ***None of these actions were taken in response to the 2018 CPS Hotline Investigation when the provider was indicated for Lack of Supervision/Neglect.***

- The documented regulatory response by the Licensing Unit was a phone call to foster mother ***six months later*** regarding the supervision of the children. Foster mother reported her mother comes over to babysit when needed. They did not confirm this support. Licensing did not follow up or run clearances for her mother. Had clearances been done, it would have been known that foster mother's mom lived in Florida.
- The Licensing worker documents concerns for this placement. However, the licensing worker seeks removal of the hold on the license so the adoption of the eighth (8th) child can go through.

III. Family Services Unit:

- Of the thirteen children placed with this foster care provider there were at least four (4) children with no documented face to face visits from their social caseworker for extended periods of time. In one case, there were no documented face to face visits for eight (8) months. In three (3) other cases, there was a four (4) month gap with no documented face to face visits. In at least two (2) cases, although face to face visits did occur with the child, visits did not happen in foster mother's home.
- Numerous cases revealed large gaps in time where there were no case activity notes entered into RICHIST. In one case, no notes were entered for eight (8) months.
- In 2012, FSU documents two (2) separate incidents where one foster child experienced seizures resulting in a call to EMS. Subsequently, the child had to be transported to the hospital. The child was transported and treated at the hospital alone. It is noted that foster mother could not go with the child due to having four (4) other children in her home. There is no other documentation by FSU that this incident prompted further discussions about foster mother's ability to provide adequate care to numerous children.

- In 2013, foster mother informs the social caseworker a toddler placed in her home had some bruising and she thinks it could be from one of the other foster children. Foster mother noted this child does not let her know if someone is hurting them. The child could be pinched and would not make a noise. She doesn't let the child out of her sight. There is no documented follow up by FSU regarding supervision, further exploration into the bruising or evaluating the children currently placed in the home. **NOTE:** This is the same child who had bruising, which was called into the Hotline in 2012 discussed in the General Findings section.
- In 2013, foster mother was notified about the upcoming reunification of one of her foster children with their biological parent. During this conversation, foster mother informs the caseworker she already contacted the DCYF placement unit to get another child once the child is reunified. According to foster mother, DCYF was identifying children that could go there next.
- In 2013, a social caseworker documented unusual behavior by foster mother. A child placed with foster mother was on a visit with their biological parent. The child was going to be reunified with their parent soon. During the visit, foster mother contacted the biological parent informing her that she would pick the child up early from the visit. Foster mother was crying and stated the biological parent would have problems taking care of the child. There is no documentation indicating that FSU followed up with foster mother regarding this behavior or completed any further assessment regarding this foster home.
- In 2013, one child placed with foster mother was reunified with biological parent. Following this reunification, the biological parent notified DCYF foster mother had not closed her case with DHS and was still receiving WIC and foods stamps for the child. This was preventing the biological parent from receiving these benefits.
- In 2013, a social caseworker made an unannounced visit to foster mother's home after being unable to reach foster mother by phone or email. The foster mother verbalized being unhappy that social worker was there. The social worker documents "She did not want SCW in the house as evidence by only opening the door a crack." Foster mother noted she should have been provided more notice. The social worker found the home to be cluttered but not unclean. There was no

documented follow up by DCYF regarding this incident. There is no documented visit to the home by the social caseworker following this interaction with foster mother.

- In 2015, an email was sent to a social caseworker from foster mother entitled “[foster mother] the semi hoarder”. In this email foster mother expresses to the social caseworker that she feels bad and does not want the social worker to feel like the child on social worker’s caseload is not in good hands. The social worker responds “You need some RELAX pills. Your not the worst hoarder LOL...I am not worried.” There were no corresponding case activity notes reflecting what the issue in this email may have been and no further evaluation of any issues that may have been present.
- In 2016, social worker and supervisor advocated for the placement of an eighth (8th) child in foster mother’s home as the child’s siblings were already placed there. FSU sought a variance from the Licensing Administrator to effectuate this placement.
 - There was no assessment performed regarding the ability of foster mother to care for an 8th child
 - There was no assessment of the responsibilities foster mother had in caring for six (6) special needs children and providing a home school education to some of the children.
 - FSU relied heavily on the fact foster mother had the space for the child, siblings were in the home and foster mother’s willingness to take the child.
- From 2016-2017, one service provider documented concerns regarding the family. Foster mother frequently cancelled visits and was not following through with the treatment plan provided.
 - The service provider contacted DCYF directly to report “safety issues and nutrition issues”.
 - The service provider documented concerns regarding one of the children being parentified at a young age. Their notes indicate the foster mother orders this child around to change, feed and care for the other children. This child was home as he was to be homeschooled, but the service provider noted that there was no evidence of any educational activities.

- Foster mother yelled at the services providers in front of the social worker and this was never addressed by DCYF.
 - This service provider also documented concerns regarding the relationship between foster mother and the assigned social worker. Foster mother referred to the social worker as “uncle” and had all the children call him that too. This reflects inappropriate boundaries.
 - Documented concerns that foster mother was providing the child with high calorie meal replacements instead of teaching the child to eat solid foods.
 - The service provider drafted a letter outlining their concerns in the case. The letter noted foster mother was utilizing tactics that are not effective for the child’s development. Additionally, the letter noted when encouraging foster mother to teach the child to use a spoon and self-feed, foster mother remarked “I have 8 kids, and I don’t know when I would have time to practice”. This letter was provided to DCYF and foster mother at a joint meeting. Foster mother became upset and ripped up the letter. This issue was not addressed, this incident was not documented by DCYF and subsequently services with this provider were terminated.
 - Upon review of their records, this service provider contacted the social worker at least seven (7) times with concerns and spoke with the social worker supervisor directly on at least one (1) occasion who indicated the case would be monitored to see if similar concerns arise.
 - These concerns were never properly addressed and DCYF subsequently assisted foster mother in switching service providers. The case activity notes in RICHIST entered by the social worker and the social worker supervisor do not reflect any of the concerns brought to their attention by this service provider or document any follow up; this provided an inaccurate depiction of the case.
- From 2017-2018, the family was involved with another service provider. Similar problems persisted including frequent cancellation of appointments and concerns regarding foster mother’s behavior ultimately prompting a CPS Hotline call.

- In 2018, the service provider arrived to an appointment at foster mother's home early. The provider observed foster mother pull into the driveway and go into the house alone. When confronted about this, foster mother noted that she went to Dunkin Donuts and dropped her other son off at school. She left the other special needs children in the care of her oldest child (13) diagnosed with Autism. The service provider also noted to the CPI that they had concerns regarding the isolation of the children, safety issues and the oldest child being parentified.
- Following the call to CPS, the service provider witnessed foster mother recording one of their visits. This issue was brought to DCYF's attention but was never addressed. This incident was also never documented by the social worker or the supervisor in the case activity notes.
- Upon review of the record, the service provider contacted the DCYF social worker at least eight (8) times with concerns and the DCYF social worker supervisor at least four (4) times with concerns. None of these contacts or concerns were appropriately documented in RICHIST or followed up on.
- Foster mother terminated services with this service provider immediately following the adoption of her eighth (8th) child.
- In 2018, the CPI directly notified the social caseworker of the call to the CPS Hotline and the findings of the investigation. The social worker noted that they had no concerns regarding foster mother and she has always met the needs of the child. There is no documented follow up by FSU with foster mother regarding the investigation, there is no documented safety planning or assessment of need and there were no referrals made for additional support services.
- According to the case activity notes, foster mother asked the social worker about the investigation just two weeks later. The social worker referred foster mother to the Licensing Unit.
- In response to the 2018 investigation, foster mother notified the social worker she had natural supports that were going to assist her with the children going forward. These supports included her church, the Elks Lodge and her mother who was going to move in with her from Florida. The social worker never contacted or verified

these supports were in place to assist foster mother. Social worker never sought clearances for the grandmother who was allegedly moving in. One month later, following the completion of the investigation, foster mother notifies the social caseworker that her mother is no longer moving in with her. This was never addressed by DCYF.

- The social caseworker had documented visits to the home, however the condition of the home as explained by the CPI was never identified as a concern or documented.
- In 2018, the social caseworker entered a case activity note into RICHIST following a visit to foster mother's home. This note indicates that during the visit the worker observed two (2) of the children in the home zipped into their "safety beds", which was described as mesh netting that covers the bed and zips. This would contain the children to their beds. There was no documented concern or follow-up regarding this practice by foster mother. ***This was just two weeks after the call to the CPS Hotline regarding foster mother.***
- Two (2) months after the 2018 CPS Investigation, there are no documented face to face visits with the child by the social caseworker. Five (5) months later, the child is adopted and the case is closed to DCYF.
- Numerous missed opportunities for social caseworkers involved to identify potential risk to the children placed in the home. Failure to act in many instances to ensure the safety and the well-being of the children placed in the home.

IV. Child Protective Services:

- In 2013, the Department of Health WIC Division contacted the Child Protective Services Hotline regarding foster mother. The reporter stated that they were investigating foster mother for selling specialized, prescription formula on Craigslist. Reporter informed CPS foster mother had ten (10) cases she was selling. Reporter also noted that if foster mother was feeding the child the appropriate amount of formula each day there is no way she should have this much left over. At the time of the investigation, the child was being treated for Failure to Thrive. Foster mother was subsequently investigated for Neglect of the child. CPS spoke with the assigned FSU worker and supervisor. They noted the foster mother had

not mentioned anything about not giving the child the formula or changing it. “While this is concerning that she would do this, at the same time there have not been any concerns of abuse/neglect.” The social caseworker reported to the CPI that it is “unknown why she would not give the child formula, what if anything she has substituted or why she would be selling the formulas as there is would be no excuse for that.” Foster mother apologized and said that the formula was about to expire and she did not want it to go to waste. Selling formula provided by WIC could be deemed a federal offense.

- The CPI, FSU and Licensing all reviewed the results of this investigation and made notes regarding the outcome; each unit minimized the allegation.
 - The CPI kept noting the home was well-stocked with the formula, however, the foster mother had not sold any because she was caught by the WIC Investigator.
 - The WIC Investigator informed the Hotline if the foster mother was feeding the child the appropriate amount, she should not have this much extra formula. The child was being treated for a Failure to Thrive. This was not addressed.
 - The question was whether foster mother was withholding this formula from the child or providing a substandard amount? Both CPS and FSU never seem to explore this issue further nor do they have the child medically evaluated.
 - The social caseworker noted the actions of foster mother are “concerning” and has a series of questions about why she wasn’t giving the formula to the child or what she was giving the child instead. These questions remained unanswered, no further action was taken, the investigation was unfounded and the child was left in the home.
- In 2014, a CPI responded to foster mother’s home to discuss an ongoing investigation. After leaving the foster mother’s home, the CPI emailed all social workers and social worker supervisors who had children in the home. The CPI also emailed two Licensing Administrators. The CPI expressed concern regarding the number of children placed in the home, noting that it was a safety concern as foster

mother did not have a lot of support. The CPI notes “[Foster mother] was attempting to get dinner ready for the 6 children. The 3 littlest were in cribs crying and waiting for foster mother

- to pick them up. Given the ages of the children this is the only way she can prepare dinner or do anything while the children are awake. Which seems like a good plan but I don’t think it is appropriate just because we have placed too many children with her that are so close in age that require a lot of attention.” The CPI was inquiring as to whether there were other concerns and if there was a plan to move any of the children soon.
 - There was little response from workers.
 - Those who did respond had no concerns and discussed no intention of moving the children they had placed there.
 - There was no other documented follow up by Licensing or FSU regarding these concerns. Subsequent to this email, DCYF placed five (5) children in this home and foster mother proceeded with the adoption of six (6) children.
- In 2018, a call is made to the Child Protective Services Hotline regarding foster mother’s home by a service provider. The reporter notified DCYF foster mother left six (6) special needs children in the care of her oldest son who is diagnosed with Autism. It was expressed that she believes foster mother is overwhelmed in the care of the children. The reporter noted she is working with the youngest child and when arriving the child is frequently contained to a playpen or bed, which is hindering the child’s progression with walking. When the CPI arrived at the home, foster mother first presented as uncooperative and stated “I do not have time for this and will not do this today.” The CPI was ultimately able to gain access to the home. The home was *cluttered and out of order with a strong odor of urine present*. The foster mother would not provide the CPI with access to the second floor, instead, she instructed her oldest child to carry each child down individually. Each child was observed to be dressed in only a diaper in January. Foster mother admitted to leaving the children with her oldest child, who has developmental delays of his own, on numerous occasions. Foster mother defended this decision and informed the CPI that the children are “secured” in their beds when she leaves.

When asked what would happen if there was an emergency, such as a fire, foster mother reported that the oldest child would be able to remove all six (6) children from the home.

- The CPI indicated the investigation for Neglect/ Lack of Supervision/No Caretaker.
- The CPI met directly with the Licensing Supervisor to review the concerns revealed during the investigation and refer the matter for “regulatory review” as this was an active licensed provider.
- The CPI met directly with the assigned social worker to review the concerns.
- When the CPI advised foster mother of the indicated investigation, foster mother again defended her decision to leave her oldest child in a caretaking role.

V. Home Studies:

- Home studies for each child submitted were repeated information from the 2007 and 2011 home studies.
- The following issues were identified regarding the home study reports:
 - The report submitted was a prior home study from 2007 with information about the child being adopted added to it.
 - Due to this being an old home study, the report contained an old address and did not reflect the information of where foster mother and this child currently lived.
 - Some reports ignore foster mother’s history of trauma, mental health issues and criminal activity.
 - There was contained no information regarding the number of other children placed in the home or their significant needs.
 - The section designated for physical, intellectual or medical issues of the child being adopted was inaccurate and missing vital medical information.
 - The section designated for the Behavioral/Emotional Challenges of the child being adopted was not an accurate reflection of the child’s previous or

current issues. This section also included behaviors/concerns, which had never been previously documented.

- Home study for the 8th adoption had the wrong address for the child.

VI. Verification of Information:

- Foster mother was utilized to supervise visitation between biological parents and children placed in her home. This presented a conflict of interest. With no DCYF staff member present for the visit, they relied solely on the account provided by foster mother.
- Foster mother was heavily relied upon to provide updates to DCYF regarding the progress of the children with services. Additionally, they sought updates regarding the child's health and progress with medical appointments directly from the foster mother. There is little to no documentation DCYF staff followed up with service providers or medical professionals.
- Following the 2018, CPS investigation, foster mother identified natural supports to assist her with the children going forward. There is no evidence that FSU, Licensing or CPS followed up with the identified supports to confirm their involvement with the family or the nature of the assistance being provided.

VII. Legal Representation of a Child:

- Upon review of DCYF records and Family Court files for the numerous children placed in foster mother's home, the following issues were identified regarding the legal representation provided by the Guardian *ad litem*:
 - We did not find any evidence that the last Guardian *ad litem* appointed to the case filed any written reports or recommendations to provide an update about the case and the placement of the child (ren) as required by Family Court Administrative Order 2015-1.
 - There were many instances where a Guardian *ad litem* should have filed an appropriate motion to ensure the child's or the children's best interests.
- Failure of the attorneys to fulfill their duties to these children was another missed opportunity to ensure the safety and well-being of the children placed in this home.
- The issues identified regarding the quality of legal representation of children in state care was addressed through an Administrative Order issued by the Chief Judge

of the Family Court. This Administrative Order took effect on June 1, 2019. The Order requires that any attorney serving as a Guardian *ad litem* for a child in state care complete the following:

- Visit the child they are appointed to represent, in their current placement following their appointment as GAL. The Guardian *ad litem* shall certify in writing to the Family Court that this visit was completed.
- Visit the child in their placement during the pendency of the case.
- Develop a written report detailing the findings of each home visit conducted, outlining the conditions, appropriateness and suitability of the child's placement.
- That the Guardian *ad litem* prepare a written report with recommendations at least prior to every permanency hearing or as requested by the court to ensure the best interests of the child are being met.
- Review and actively monitor the execution of case plans and transition plans to ensure that services are being delivered to the child and the child's family.
- Attend all court proceedings, file appropriate motions and make recommendations on behalf of the child to ensure the best interests of the child are being met.

DEPOSITIONS

The Child Fatality Review Panel decided to depose several DCYF employees and a court appointed guardian *ad litem* who represented several of the children placed in the home so that we could ask them questions to get a better understanding of what occurred and what needs to be changed within the child welfare structure.

The panel deposed the following six individuals: two Licensing Administrators, the Court Appointed Guardian *ad litem*, a Social Caseworker and two Caseworker Supervisors.

The Social Caseworker

- Through his/her own admission, the Social Worker advocated for the placement of Child #8 to be at the home because “no other placements were available in Rhode Island”

- Through his/her own admission, the Social Worker did not verify any of the names of individuals who were named as part of the “support system” to this foster/adoptive parent. Specifically, when asked under oath he/she had no recollection of calling, meeting or contacting in any way the individuals named.
- Through his/her own admission, he/she never observed a living area for foster mother’s mother who was alleged to be moving in, nor did he/she ever meet this support.
- Through his/her own admission, it was not a concern to this worker that foster mother was a single parent with 8 special needs children. When asked what was compelling about foster mother that would indicate she could handle 8 special needs children on her own, the worker replied “...she had providers for most if not all the children at one point in time. They were ongoing.”
- Subsequently, worker was asked whether the services in place for the family were long-term services. The worker replied “No”. When asked if the Department considered foster mother’s capacity to deal with 8 children upon the termination of those services, the worker answered “No.”
- Through his/her own admission, the Social Worker testified to having known about the “security mesh tents” used in this home and observed them during one of his/her home visits. They testified that he/she had never seen these used in any other case they have ever had as a DCYF employee.
- When asked why foster mother was using these enclosures, the Social Caseworker reported that they were in use due to the children being autistic, to prevent them from getting out of the bed and that he/she understood that this was recommended by providers. Through his/her own admission the Social Caseworker never confirmed with providers that this was recommended. When asked, the Social Caseworker confirmed that the children would need assistance to get out of the “security mesh tents”.
- Although not on his/her caseload, the Panel found it interesting that this worker testified that he/she only recalled seeing child “A” who is wheelchair bound, twice. This worker was involved with the family for at least four (4) years, which would equate to approximately 48 visits to the home. When asked where the child was, the worker replied that the child could be with providers or at a doctor’s appointment, however, he/she could not explain how that could occur if he/she was with foster mother during the visit.

- Through his/her own admission, the Social Caseworker knew that the children were being homeschooled but never witnessed a lesson in progress during visits.
- Through his/her own admission, the Social Caseworker never reviewed the CPI's report of the 2018 investigation.

Caseworker Supervisor #1

- Through his/her own admission, the Caseworker Supervisor #1 admitted that today they would not support the placement of Child #7 or Child #8.
- They described a pilot program now being used, the RED Team approach, which stands for review, evaluate, decide. This is a larger meeting of all parties involved including several administrators to make a group decision weighing all factors of the case, and that in their estimation the RED team would NOT approve these placements.

Caseworker Supervisor #2

- Through his/her own admission, the Caseworker Supervisor #2 admitted that today they would not support the placement of Child #8.
- They described the pilot program (see above) and in their estimation said that this RED team approach would NOT approve this placement
- Through his/her own admission, the Social Caseworker mentioned above allowed "...[his/her] emotions and [his/her] feelings towards the family or the child sometimes cloud [his/her] thinking."
- Upon being questioned by DCYF Counsel, this Supervisor agreed that DCYF attempted to maintain a lower caseload for the Social Worker mentioned above. This was noted to be more beneficial.
- Through his/her own admission caseloads remain high for caseworkers with one social worker in their unit having 18 cases and 32 children on their caseload.

Licensing Administrator #1

- Through their own admission, this Licensing Administrator admitted that staff shortages have affected the work product of the Licensing Unit. "There is not a schedule. There is—it's very case by case. Quite frankly, with the number of cases that they all have or the

number of homes assigned to them there would be no way for them to be able to visit every foster home or entity that they have on their case load” and “yes, there is a capacity issue in the 2018 situation, with so many competing priorities, licensing worker should have immediately followed up ... generally speaking there is a lot on their plate”

- When asked how many more people are needed presently in Licensing, they responded that “5 to 8 more people are needed in licensing”.
- Through their own admission, this Licensing Administrator admitted the new process is more comprehensive “Now it’s communication with the FSU and that they are looking at what we’ve outlined, sort of ten areas that need to be looked at in making any of these kinds of decisions”.
- Through their own admission, this Licensing Administrator said that there was no protocol in Licensing when an indicated CPS report was received in one of their homes, “There is currently. When I first started, I don’t think that process was particularly clear. People had been doing it for years in whatever way they were doing it”.
- In contrast, now the department has “a regular weekly review, by all the administrators” to discuss indicated cases in foster homes.
- When asked about what they would have done about retraining or reeducating the foster mother after the indication of February 2018, “I would have gone more towards what services, who else is in the home, can we connect, make referrals, does she have natural supports, other structures and supports.”
- When asked, they did not know that CPI *** had come to the licensing worker and the FSU worker directly to discuss the indicated case.
- When asked what follow up would be done by licensing once they are notified of an indicated investigation: “there’s an expectation that there would need to be some sort of follow up. At a minimum a communication with FSU to see when recent follow up was, but some sort of follow up; where it’s a phone call, or a visit. They wouldn’t always be required to go out. “
- When asked about evaluating potential foster parent who have their own trauma history, this Administrator responded “their past experience with children within their own family. Their own trauma history. Their own upbringing. The way that they were disciplined. Their own philosophy on child rearing.”

- When asked about why the applicant's own childhood experience is important, they answered: "...much of what somebody learns in how to parent is reflective of how they themselves were parented. It gets at any sort of trauma history that they have that might be triggered while they're dealing with children with, you know, trauma experiences, things of that nature."
- When asked whether there is a hard and fast rule about a prospective foster parent who may have been severely abused, and what would be considered they answered: "There is not a hard and fast rule, no...the whole safe home study process is set up to figure out mitigation of these sorts of things. So identification, and then has that been mitigated? Have they been through therapy? Have they addressed it with their own parents? How do they currently think about it?...So it's about mitigating."
- Also, when asked about psychiatric information regarding a prospective foster parent, they responded: "So that would come out either in the form of the home study, or in a physician's reference, and we can ask for more documentation about if, you know, if there is a mental health provider of any type, and yes, that would be considered."
- When asked about retraining of FM after the indication- "I would have gone more towards what services, who else is in the home, can we connect, make referrals, does she have natural supports, other structures and supports".
- This Administrator was asked what they personally reviewed prior to making the decision to grant the variance to allow an 8th child to be placed in foster mother's home in 2018. They replied: "I relied heavily on the information that was coming to me and from staff that were saying that everything seemed fine. So I was relying on, you know, the FSU worker and supervisor saying that the placement or that the home was a good home. That it was, you know, the best fit for the child. I was relying on the licensing staff who have been in licensing to have let me know if any of those things that we talk about were not, you know, true. That we didn't believe those things were happening."

Licensing Administrator #2

- Through his/her own admission, this Licensing Administrator repeatedly said that the Licensing unit is not fully staffed and that this shortage has directly affected their ability to do the work required. Specifically, that there was a lack of employees in the Licensing Unit

in 2018 to do the proper assessments or investigations. They said that they would need between 13 to 15 more employees to do the work properly.

- Through his/her own admission, this Licensing Administrator admitted deficiencies in their response to indicated investigations on a licensed foster home. They admitted to an overreliance on the information received from the Family Services Unit and admitted that they did not independently verify any information, especially when they were short on staff. He/She said the staffing is still an issue presently.
- When asked whether he/she is confident that licensing will no longer be a rubber stamp for FSU in a similar situation, he/she testified that “decisions made going forward will not be rubber stamped just by what an FSU report gives us.”
- Through his/her own admission, this Licensing Administrator said that the process has now changed as of January 2019. They described a weekly meeting with the Department’s administrators to include any unit that has been involved with the case.
- Through his/her own admission, this Licensing Administrator confirmed that there was no process to ensure that the Licensing Worker had followed through with the foster mother to reiterate that she could not leave the children alone. Also, they said no one from Licensing went to this home to address the concerns outlined by the CPI in February 2018. This did not deviate from the standard. There was just an “operational expectation” for someone in Licensing to follow up via telephone.
- Through his/her own admission, this Licensing Administrator acknowledged that no one from Licensing had ever confirmed the foster mother’s natural supports. Specifically, no one met or spoke with any of the listed supports.
- Through his/her own admission, this Licensing Administrator acknowledge that the Licensing Unit cannot go out and assess homes if they are short employees. When asked, they said that visits occur when they need to address issues. They admitted that leaving eight special needs children alone in a home and a foster parent who secures children in mesh security tents when she goes out as examples of issues that would “rise to the top”. However, no such visit occurred.
- Through his/her own admission, this Licensing Administrator admitted that she had approved the variance which allowed the last child to go this home in June 2016. She admitted that she relied on others in making this decision since she and her supervisor

(Chief of Licensing) were both new to their roles. They relied on the assertions of FSU to approve this waiver. They admitted they would have sent someone one from the Licensing Unit if they had the capacity, or the employees to do so. They had no one to do “proactive monitoring”

- Through his/her own admission, this Licensing Administrator followed the directives of the former acting director, to seek kinship; placement whenever possible: “it was made very clear to me through our acting director at the time that for a variety of reasons kinship placement was a primary factor and was an ultimate determinant of whether or not we were going to place a child in a home”.
- Through his/her own admission this administrator voiced his/her concerns regarding the capacity issues to the former acting director and to her supervisor, the Chief of Licensing, in person.
- Through his/her own admission in 2018, this administrator stepped away from managing the day to day operations of licensing to focus on a larger project. This administrator also admitted that no one had formally relieved them of their duties to manage or supervise the day to day operations, they had to “...adjust capacity internally to meet all of the needs of the directives that we were given.”

The Guardian Ad Litem

- The GAL testified that they could not access their file due to time constraints. They were served on a Saturday and were deposed on Wednesday afternoon.
- They could not specifically recall going to the home of these children.
- They did not recall anything about their wards’ disabilities.

DCYF with its social workers, supervisors and administrators, created this situation. Over the course of thirteen years, they had multiple opportunities to intervene. Through complaints from the community, observations from their own employees and by concerns relayed by service providers, there were numerous opportunities to intervene and to prevent the death of this child. There will never be a realistic answer to the question of ***how can one person care for eight special needs children?*** It is our opinion that DCYF needs to be held responsible and accountable. Certain employees of DCYF showed poor judgment and disregard for the safety of the children in this

home. We maintain that the actions, or inactions of DCYF staff contributed to the death of this child.

RECOMMENDATIONS

1. The Department should improve the verification information that is self-reported by case participants. This information should be verified with the service provider or other relevant entities prior to closing a CPS investigation, termination of DCYF involvement, while a case is open or prior to approving relative or other foster care licenses.
2. That the Department increase both pre-adoption and post-adoption supports and services to ensure a comprehensive and realistic plan is in place for the family. Post-adoption services should be provided for a length of time deemed appropriate based on the needs of the child. That the Department provide consistent and clear oversight in the adoption process.
3. That the Department develop an in-depth home study process and ensure there is clear policy for the initial home study and all updates to address family functioning including, income, health, mental health, transportation and other personal characteristics that are important to ensure the safety and well-being of a child.
4. That the Department develop and mandate specialized training for any prospective foster parent prior to taking in a child with special needs. Medical professionals with expertise in this field should be consulted.
5. That the Department develop a policy and process to ensure that children in state care are receiving the benefits of community integration and social contacts. Seclusion and deprivation from this can result in a negative influence on the potential for normal growth and development of children, especially children with disabilities.
6. The Department develop a strict policy requiring that prior to placing a child in a foster home, a written, in-depth assessment of the ability of the provider be completed. This should include the assessment of each individual in the home, including children, and their individual needs. This assessment should occur during the re-licensing process and prior to placing additional children in the home.
7. The Department develop a strict policy that no variance is to be granted without a team meeting comprised of administrators, assigned social workers, assigned caseworker

supervisors, and relevant staff from the Licensing Unit. This review should incorporate the written assessment of the provider's ability discussed in the previous recommendation.

8. That the Department develop clear policies and protocols in response to a Hotline call about a foster child and/or a foster home. The responsibilities of each Unit should be outlined to appropriately respond to the allegations. The policies and procedures should outline the expectation of communication internally to all necessary parties including supervisors and senior administration. The policies and procedures should outline the steps to be taken upon receipt of information to ensure the safety and well-being of the child.
 - a. Any Indicated investigation of a foster home should immediately prompt a visit to the home by the FSU Unit and the Licensing Unit to complete an in-depth assessment of the home. Upon completion of this assessment, Licensing and FSU shall consult with administration to determine appropriate next steps.
 - b. The Department develop clear expectations of the Licensing Unit when completing a regulatory review, instituting strict timelines for the completion and ensuring subsequent action is reviewed and approved by the Chief of Licensing.
9. That the Department require an evaluation by the Aubin Center when there is suspected abuse and/or neglect of a foster child.
10. That DCYF staff participate in training facilitated by a pediatric child abuse specialist to recognize the early signs/symptoms of child abuse and neglect.
11. Pursue legislative and policy change providing strict regulation of the homeschooling of children with an IEP and heightened oversight by the Department of Education.
12. Pursuant to statutory authority, the Office of the Child Advocate is to develop a training for attorneys serving as a Guardian *ad litem* to children involved with the Department. The Office of the Child Advocate will collaborate with the RI Family Court.
13. That the Department provide a completed home study packet to the Court and all relevant parties at least fifteen (15) days prior to any adoption to provide time for review, independent verification of information and the opportunity for clarification on the information being provided.
14. The Department improve and increase public education regarding mandatory reporting with a focus first on the public-school system.

15. The Department re-evaluate the process they use for updating the Court to ensure comprehensive and accurate information is relayed to the Court and all parties.
16. The Department develop a structured staff supervision model and corresponding policies to ensure that all supervisors and administrators are thoroughly reviewing cases.
17. The Department prohibit foster families from switching service providers for foster children unless the decision is made by the FSU worker and approved by the FSU Supervisor after careful review of documentation and recommendations of the service provider.
18. The Department develop a strict policy regulating respite placements and provide heightened oversight to their approval. Respite placements with foster families who are already at the maximum number of children shall not be permitted.
19. The Department should develop a supervisor training curriculum, mandatory for any staff member promoted or hired in a supervisory role. This training should be provided on an on-going basis to all supervisors and administrators.
20. The Department review and enhance their training curriculum for all front-line staff.
21. The Department should hire additional front-line staff in all divisions.